

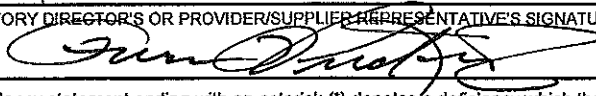
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

NOV 19 2012

PRINTED: 11/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/08/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT			STREET ADDRESS, CITY, STATE, ZIP CODE 160 WINSTEAD AVE ROCKY MOUNT, NC 27804	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	<i>This plan of correction is the center's credible allegation of compliance.</i>	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to administer a medication correctly resulting in the resident receiving 19 doses	F 329	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> I. Resident # 239's attending physician was notified and new orders were obtained to monitor blood pressure every shift for 24 hours and report back. Benazepril was re-written on the medication administration record for the correct time on a daily basis. II. Current residents' physician order sheets have been reviewed to ensure accurate dosing and medications records of current orders.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

 Administrator

TITLE

(X6) DATE

11/19/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 329	<p>Continued From page 1</p> <p>instead of the 7 ordered for 1 of 10 (Resident #239) sampled residents. Findings include:</p> <p>Resident #239 was admitted to the facility on 10/26/12 with cumulative diagnoses of hypertension (high blood pressure) and diabetes.</p> <p>Resident #239's admission Minimum Data Set (MDS) dated 11/2/12 indicated that Resident #239 was cognitively aware.</p> <p>Review of Resident #239's blood pressure readings for October 2012 showed they ranged from 129/77 to 107/66. Blood pressure readings for November 2012 ranged from 109/65 to 105/74 and did not show a significant decrease in blood pressure.</p> <p>Review of Resident #239's Admission Orders Record dated 10/26/12 showed an order for benazepril 40 milligrams (a medication used to treat high blood pressure) to be given by mouth once each day (QD).</p> <p>Review of Resident #239's Medication Administration Record (MAR) for October 2012 showed the benazepril was given once each day.</p> <p>Review of Resident #239's Physician's Orders dated 11/1/12-11/30/12 showed an order for the benazepril to be given three times each day (TID).</p> <p>Review of Resident #239's MAR for November 2012 revealed documentation that the benazepril was given three times each day from 11/1/12 through 11/6/12 and once on 11/7/12.</p>	F 329	<p>III. Staff development coordinator has provided education to licensed nursing staff to review transcription of telephone order process and monthly recapitulation of resident physician orders. ADNS/DNS to review telephone orders for accuracy of telephone order transcription to current medication administration record. DNS/ADNS to review new admission orders for data entry accuracy for 1 month, then 5 new admissions a week for 1 month, then bi-weekly for 2 months. DNS/ADNS to audit 15 random residents monthly for accuracy of monthly orders for 3 months. DNS/ADNS to audit 10 telephone orders weekly for accuracy of transcription orders for 2 months, then bi-weekly for 2 months.</p>		

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F 329	<p>Continued From page 2</p> <p>In an interview on 11/7/12 at 3:41 PM, the Data Entry Clerk stated when she input the order for the benazepril she mistakenly entered TID instead of QD.</p> <p>In an interview on 11/7/12 at 11:05 AM, the Assistant Director of Nursing (ADON) stated she was the nurse who had compared the October MAR to the November MAR to check for errors. The ADON indicated that the benazepril TID was a data entry error on the November MAR and that she had overlooked it when she compared the November Physician Order Sheet (POS) to the October MAR.</p> <p>In an interview on 11/7/12 at 11:50 AM, the Director of Nursing (DON) stated she expected the nurses doing the MAR checks to catch any mistakes so medication errors did not occur.</p> <p>In an interview on 11/7/12 at 3:20 PM, Nurse #1 indicated that giving three doses of a medication to treat high blood pressure instead of one could cause low blood pressure, fainting or weakness. She stated that Resident #239 had never complained of any of these things.</p> <p>In an interview on 11/7/12 at 3:30 PM, Nurse #2 stated that giving excessive high blood pressure medicine could cause a stroke, low blood pressure, or dizziness that could result in a fall. She indicated that Resident #239 had never complained to her of low blood pressure symptoms.</p>	F 329	IV. The results of the DNS's monitoring will be presented and discussed at the Monthly Performance Improvement Committee Meeting and additional training to be provided as needed.	11/20/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED DEC 21 2012 12/06/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT			STREET ADDRESS, CITY, STATE, ZIP CODE 160 WINSTEAD AVE ROCKY MOUNT, NC 27804	
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K 000	INITIAL COMMENTS	K 000	<i>This plan of correction is the center's credible allegation of compliance.</i>	
K 038 SS=D	A. Based on observation on 12/06/2012 the building type was V 111 and the facility was fully sprinkled with a wet system with delayed egress locking system. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 056 SS=D	This STANDARD is not met as evidenced by: A. Based on observation on 12/06/2012 the exit door from the dining room was very hard to open. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	<ol style="list-style-type: none"> The exit door in question has been adjusted and now opens easily. The Maintenance Director has inspected all exit doors in the building to determine if they open appropriately when attempting to exit. Any doors requiring adjustments to allow them to open easily were made. The Maintenance Director or his designee will inspect all exit doors for proper operation on a weekly basis. Documentation of his inspections will be kept in the Preventative Maintenance Notebook for door checks. The results of the weekly inspections of the exit doors will be shared with the Performance Improvement Committee during our monthly meetings. The Executive Director will monitor to ensure the inspections are done and any adjustments that may be needed are completed. 	12-21-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE _____ (X6) DATE 12/17/12

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ROCKY MOUNT			STREET ADDRESS, CITY, STATE, ZIP CODE 160 WINSTEAD AVE ROCKY MOUNT, NC 27804	
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K 056	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 12/06/2012 the sprinkler piping in the attic had heat tape on it for freeze protection. The noted area was located over the laundry. B. Based on observation on 12/06/2012 the bathing area on the front hall was being used for storage and had one area that was not covered by the sprinkler. 42 CFR 483.70 (a)	K 056	<p>K 056</p> <p>A.</p> <ol style="list-style-type: none"> 1. The heat tape applied to the sprinkler piping in the attic above the laundry has been removed. 2. An inspection of the other sprinkler piping in the attic covering the remainder of the facility has been completed. Any areas that may have had heat tape on the sprinkler piping have had it removed. 3. The Executive Director has met with the Maintenance Director, his assistant and the District Maintenance Consultant to discuss this concern. In the future heat tape will not be used in this facility or any other Kindred building. 4. The results of our findings of the attic inspection of the sprinkler piping will be shared during our next monthly Performance Improvement Committee. The Executive Director will be responsible for monitoring to ensure all the heat tape has been removed and that it will not be reinstalled. <p>K 056</p> <p>B.</p> <ol style="list-style-type: none"> 1. The area in the front hall storage has had a new sprinkler head installed. 2. We have inspected the other storage areas, shower rooms and utility rooms to ensure proper coverage by the sprinkler system. All areas are properly covered. 	12-21-12